

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 400

1. PLACE OF DEATH: **BUCHANAN**  
 (a) County \_\_\_\_\_  
 (b) City or town ST. JOSEPH  
(If outside city or town limits, write "RURAL," and name of township)  
 (c) Name of hospital or institution: STATE HOSPITAL No. 2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 hrs 3 mos, 2 ds.  
(Specify whether  
 In this community 5 yrs 2 mo, 2 ds.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MO. (b) County Jackson  
 (c) City or town H. C.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2614 E. 9th.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A? 1 years.

3. (a) PRINT FULL NAME James O'Hare  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Apr. day 7  
 year 1941 hour 4-30 minute 0 P. M.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
 alive \_\_\_\_\_ years  
 7. Birth date of deceased Feb. 25 1907  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 5, 1936 to Apr. 7, 1941  
 that I last saw him alive on Apr. 7, 1941  
 and that death occurred on the date and hour stated above.

| 8. AGE: | Years     | Months   | Days      | If less than one day |
|---------|-----------|----------|-----------|----------------------|
|         | <u>34</u> | <u>1</u> | <u>12</u> | hr. _____ min. _____ |

Immediate cause of death Pulmonary tuberculosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

9. Birthplace unk. MO. D  
(City, town, or county) (State or foreign country)

Other conditions has been mentally  
(include pregnancy within 7 months of death)  
incapable for years.  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

10. Usual occupation clerical

11. Industry or business \_\_\_\_\_  
 12. Name Coradine O'Hare  
 13. Birthplace Wagoner Mo.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Anna Weather  
 15. Birthplace Blende  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
85 \_\_\_\_\_  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant Cor. O'Hare, 2614 E. 9th.  
 (b) Address H. C. Mo.

17. (a) Removal (b) Date thereof 4/8/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation 14 c. Mo.

18. (a) Signature of funeral director A. E. Snow  
 (b) Address 14 c. Mo.

19. (a) 4/8/41 (b) H. J. Westphal  
(Date received local registrar) (Registrar's signature)

PHYSICIAN  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

23. Signature J. J. O'Dell (M. D. or other) D. M. O.  
 Address St. Joseph Date signed 4/8/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*me*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*R. E. Snow*

Licensed Embalmer No. ....

*2560*

P. O. Address.....

*R. E. Snow*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**